



ALLAN RAWLAND, MSW, ACSW
Director

Request for Cost Center Number

☐ Contract Agency

☐ County Operated

Name of Provider: _____

Street Address: _____

City: _____ State: ____ Zip: _____

Telephone Number: _____

Proposed Start Date: _____

Mode of Service: (Check Only One, or One and Mode 45)

☐ 05 Acute and Residential 24-Hour Services

☐ 45 Outreach and Community Programs

☐ 10 Day Treatment Programs & Crisis Stabilization

☐ 55 MAA Services

☐ 15 Mental Health Service Programs

☐ 60 Support Services

Services to be Provided:

☐ Case Management /Brokerage (15,01)

☐ Crisis Stabilization (10,20, & 25)

☐ Crisis Intervention (15,70)

☐ Mental Health Services (15,10, & 30)

☐ Medication Support: (15,60)

☐ Day Rehabilitation

☐ Full Day

☐ ½ Day (10,95)

☐ Psychiatrist visit only

☐ Day Intensive

☐ Full Day

☐ ½ Day (10,85)

☐ Dispensing Medications

☐ TBS Services

Contact Person: _____

Contact Number: _____

Email: _____

For DBH Fiscal Office Use Only:

Cost Center: _____

Facility Representative

Date

Fiscal Representative

Date

BOP023